STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445486	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGETOP HAVEN HEALTH CARE CENTER	2002 GREER ROAD GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined, the facility failed to maintain the emergency alarm system as required. National Fire Protection Association (NFPA) 72, 4-4.3.1; 101, 9.6.1. The findings included: On 4/26/10 at 3:55 PM observation during the fire drill revealed the strobe light in the lobby area was blocked by a structural beam and was therefore not visible when it was flashing. The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/26/10.	K 052	**K052 Life Safety Code Standard** 1. The strobe light was lowered on May 17, 2010. 2. All residents have the potential to be affected by this deficient practice. 3. The Environmental Services Manager was in-serviced by the fire alarm company on the proper height of strobe light placement on May 17, 2010. 4. The Administrator and the Quality Improvement Committee (Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Service/Activities Director, Therapy Manager, Medical Director, Environmental Services Manager and Dietary Manager) oversee this process to ensure compliance.	5-17-10
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dahlen T Jordan	Administrator	5-12-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND MAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445486	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGETOP HAVEN HEALTH CARE CENTER	2002 GREER ROAD GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined, the facility failed to protect the flammable containers as required. National Fire Protection Association (NFPA) 55, 6.6; 99. The findings included: On 4/26/10 at 3:00 PM observation within the oxygen closet storage in the lobby area revealed there were three oxygen cylinders not secured. The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/26/10.	K 130	**K130 Life Safety Code Standard** 1. The three oxygen cylinders were secured on April 28, 2010. 2. All residents have the potential to be affected by this deficient practice. 3. The Environmental Services Manager and facility staff was in-serviced by the administrator on May 19, 2010, regarding the proper storage of oxygen cylinders. 4. The Administrator and the Quality Improvement Committee (Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Service/Activities Director, Therapy Manager, Medical Director, Environmental Services Manager and Dietary Manager) oversee this process to ensure compliance.	5-19-10
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined, the facility failed to maintain the electrical system as required. National Fire Protection Association (NFPA) 70, 110-12. The findings included:	K 147	**K147 Life Safety Code Standard** 1. Repaired electrical splice with junction box on April 29, 2010. 2. All residents have the potential to be affected by this deficient practice. 3. The Environmental Services Manager was in-serviced by the Administrator on April 29, 2010. 4. The Administrator and the Quality Improvement Committee (Administrator, Director of	4-29-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

4/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445486	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGETOP HAVEN HEALTH CARE CENTER	2002 GREER ROAD GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 2 On 4/26/10 at 3:55 PM observation within the long hall ceiling area above resident rooms 13 and 15 revealed there was an electrical splice which was not in a junction box. The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/26/10.	K 147	Nursing, Assistant Director of Nursing, MDS Coordinator, Social Service/Activities Director, Therapy Manager, Medical Director, Environmental Services Manager and Dietary Manager) oversee this process to ensure compliance.	